CLINICAL RECORDS MANAGEMENT

CR.1
The organization maintains a written clinical record on each patient.

CR.1.1 The clinical record describes the patient's health status at the time of admission, the services provided, the patient's progress in the organization, and his/her health status at the time of discharge

CR.1.2 When indicated, the clinical record contains documentation that the rights of the patient and his/her family are protected.

CR.1.2.1 The clinical record contains any advance directives for medical care.

CR.1.3 The clinical record contains documentation of the patient's and, as appropriate, family members' involvement in his/her treatment program.

CR.1.3.1 When appropriate, a separate record is maintained on each family member involved in the patient's treatment program.

CR.1.4 The clinical record contains identifying data recorded on standardized forms.

CR.1.4.1 Identifying data include the following:

CR.1.4.1.1 name;

CR.1.4.1.2 home address;

CR.1.4.1.3 home telephone number;

CR.1.4.1.4 date of birth;

CR.1.4.1.5 sex;

CR.1.4.1.6 race or ethnic origin;

CR.1.4.1.7 next of kin;

CR.1.4.1.8 education;

CR.1.4.1.9 marital status;

CR.1.4.1.10 type and place of employment;

CR.1.4.1.11 date of initial contact or admission to the organization;

CR.1.4.1.12 legal status, including relevant legal documents;

CR.1.4.1.13 other identifying data as indicated;

CR.1.4.1.14 date the information was gathered; and

CR.1.4.1.15 signature of the staff member gathering the information.

CR.1.5 The clinical record contains information on any unusual occurrences, such as the following;

CR.1.5.1 treatment complications;

CR.1.5.2 accidents or injuries to the patient;

CR.1.5.3 morbidity;

CR.1.5.4 death of a patient; and

CR.1.5.5 procedures that place the patient at a risk or cause unusual pain.

CR.1.6 As necessary, the clinical record contains documentation of the consent of the patient, appropriate family members, or guardians for admission, treatment, evaluation, continuing care, or research.

CR.1.7 The clinical record contains documentation of both physical and emotional diagnoses that have been made using a recognized diagnostic system.

CR.1.8 The clinical record contains reports of laboratory, radiologic, or other diagnostic procedures and reports of medical/surgical services when performed.

CR.1.9 The clinical record contains correspondence concerning the patient's treatment and signed and dated notations of telephone calls concerning the patient's treatment.

CR.1.10 A discharge summary is entered into the clinical record within 15 days following discharge.

CR.1.11 The clinical record contains a plan for continuing care.

CR.1.12 All entries in the clinical record are signed and dated.

CR.1.12.1 Symbols and abbreviations are used only if they have been approved by the professional staff and only when an explanatory legend exists.

CR.1.12.2 Symbols and abbreviations are not used when recording diagnoses.

CR.1.13 If a patient dies, a summation statement is recorded in a discharge summary.

CR.1.13.1 The summation statement describes the circumstances leading to death and is signed by a physician.

CR.1.13.2 An autopsy is performed whenever possible.

CR.1.13.2.1 When an autopsy is performed, a provisional anatomic diagnosis is recorded in the clinical record within 72 hours.

CR.1.13.2 The completed protocol is made part of the clinical record within three months.

CR.2
The organization appoints a staff member to maintain, control, and supervise clinical records and to be responsible for maintaining their quality.

CR.2.1 A qualified record administrator or technician who is available on at least a part-time basis, consistent with the needs of the organization and professional staff, is responsible for the record information systems.

CR.2.2.1 When it can be demonstrated that the size, location, or needs of the organization do not justify employment of a qualified records individual, the organization secures the consultative assistance of a qualified record administro or an accredited record technician.

CR.2.2 Appropriate clinical records are kept on the unit where the patient is being treated and are directly accessible the clinicians care for him/her.

CR.2.3 Written policies and procedures govern the compilation, storage, processing, and handling of clinical records.

CR.2.4 The organization provides adequate facilities for the storage, processing, and handling of clinical records, including suitable locked and secured rooms and/or files.

CR.2.5 When an organization stores patient data in electronic or other types of automated information systems, adequate security measures prevent inadvertent or unauthorized access to such data.

CR.2.6 The organization maintains an indexing or referencing system that can be used to locate a clinical record that has been removed from the central file area.

CR.2.7 A written policy governs the disposal of clinical records.

CR.2.8 The organization has written policies and procedures that protect the confidentiality of clinical records and govern the disclosure of information in the records.

CR.2.8.1 The policies and procedures specify the conditions under which information on applicants or patients may be disclosed and the procedures for releasing such information.

CR.2.8.2 A patient or his/her authorized representative may consent to the release of information provided that written consent is given on a form containing the following information:

CR.2.8.2.1 name of the person, agency, or organization to which the information is to be disclosed;

CR.2.8.2.2 specific information to be disclosed;

CR.2.8.2.3 purpose of the disclosure;

CR.2.8.2.4 date the consent was signed and the signature of the individual witnessing the consent; and

CR.2.8.2.5 notice that the consent is valid only for a specified period of time.

CR.2.8.3 The written consent of the patient, or that of a representative authorized by the patient, to the disclosure of information is considered valid only if the following conditions are met:

CR.2.8.3.1 the patient or the representative is informed, in a manner calculated to assure his/her understanding, of the specific type of information that has been requested and, if known, the benefits and disadvantages of releasing the information;

CR.2.8.3.2 the patient or the representative gives consent voluntarily;

CR.2.8.3.4 the consent to the patient is acquired in accordance with applicable law and regulation.

CR.2.8.4 Every consent to the release of information, the actual date the information was released, and the signature of the staff member who released the information are part of the clinical record.

CR.2.8.5 Staff members and other persons having access to clinical records are required to abide by the written policies regarding confidentiality of clinical records and disclosure of information in the records, as well as applicable law and regulation.

CR.2.8.6 IN a life-threatening situation or when a patient's condition or situation precludes the possibility of obtaining written consent, the organization releases pertinent medical information to the medical personnel responsible for the patient's care without his/her consent and without the authorization of the chief executive officer or a designee, if obtaining such authorization would cause an excessive delay in delivering treatment of the patient.

CR.2.9 When information has been released under emergency conditions, the staff member responsible for the release of information enters all pertinent details of the transaction into the clinical record.

CR.3
Clinical records comply with applicable law and regulation.

CR.4
The organization provides for a mechanism(s) that facilitates the patient referral and provides consultation between the organization's program components and between the organization and other service providers in the community.

CR.4.1 The referral methods are designed to provide for continuity of care for the patient.